Physical Therapy &
Sports Medicine

Assignment of Benefits

Practice Name: Diablo Physical Therapy and Sports Medicine
Address: 315 Diablo Rd. Ste 110, Danville, Ca 94526
Patient:_____ID#:_____
Phone: _____Group#:_____

I, _____, understand that services rendered to me by **Diablo Physical Therapy and Sports Medicine** are my financial responsibility and that the provider will bill my insurance company _____, as a courtesy. I authorize my insurance company to pay my benefits directly to Diablo Physical Therapy and Sports Medicine and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and coinsurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by _____(insurance company).

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to Diablo Physical Therapy and Sports Medicine within 48 hours. I agree that if I fail to send the payment to Diablo Physical Therapy and Sports Medicine and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. If I receive any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to Diablo Physical Therapy and Sports Medicine. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize Diablo Physical Therapy and Sports Medicine to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize Diablo Physical Therapy and Sports Medicine to initiate a complaint or file an appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Dated_____ Witness _____

_____ _____

Signature of policyholder Patient or Guardian

Physical Therapy &
Sports Medicine

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for DIABLO PHYSICAL THERAPY & SPORTS MEDICINE to furnish medical care and treatment to _____considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian_____ Date_____

Patient Information Acknowledgement Form

I have read and fully understand DIABLO PHYSICAL THERAPY & SPORTS MEDICINE's Notice of Information Practices. I understand that DIABLO PHYSICAL THERAPY & SPORTS MEDICINE may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that DIABLO PHYSICAL THERAPY & SPORTS MEDICINE will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in DIABLO PHYSICAL THERAPY & SPORTS MEDICINE's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient/Guardian_____ Date_____

315 Diablo Rd. Suite 110 | Danville, CA 94526-3409 | 925.855.8350 Phone | 925.855.8351 Fax

Physical Therapy &
Sports Medicine

PATIENT INFORMATION FORM

Reason for Today's visit: _____

Name:_____ Sex: ____M_____F

Home Phone:_____ Work Phone:_____ Cell Phone_____

Home Address:_____ City:_____ Zip Code:_____

Patient Social Security #:_____ Date of Birth_____

Driver's License #: _____ State_____ Expiration Date:_____

Email address:_____

Marital Status: Married Divorced Legally Separated Widowed Single

Nearest Relative not living with you:_____ Phone #:_____

Whom may we contact in case of an emergency:_____ Phone#:_____

Whom may we thank for referring you to us?_____ Phone#:_____

Are you currently employed? ☐ Yes ☐ No

Are you covered under any other health care plan? ☐ Yes ☐ No

Did you sustain an injury at work? ☐ Yes ☐ No

Are your injuries accident related? ☐ Yes ☐ No

Accident or Injury Information

If yes, please provide details of the accident: Date and Location:_____

Details of accident or injury:

_____

_____

_____

Did you consult another physician regarding any other injuries resulting from this accident? ☐ Yes ☐ No

If yes, Name of Physician:_____ Date first seen by other physician:_____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above questions. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information. This information will be kept confidential. I am aware that a copy of my insurance identification card will be made available and a copy kept in my records. I am responsible for updating this information if and when there are changes.

_____ _____

Signature Date